

<i>SERFF Tracking Number:</i>	<i>MUTM-126940969</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>United of Omaha Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>47577</i>
<i>Company Tracking Number:</i>	<i>LISA KOCH</i>		
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>Master Policy 2010 - 7000GM-U-EZ 2010</i>		
<i>Project Name/Number:</i>	<i>Master Policy 2010/7000GM-U-EZ 2010</i>		

## Filing at a Glance

Company: United of Omaha Life Insurance Company

Product Name: Master Policy 2010 - 7000GM- SERFF Tr Num: MUTM-126940969 State: Arkansas  
U-EZ 2010

TOI: H21 Health - Other

SERFF Status: Closed-Approved- State Tr Num: 47577  
Closed

Sub-TOI: H21.000 Health - Other

Co Tr Num: LISA KOCH

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Mary Cleasby, June  
Rodgers, Mike DiLorenzo, Neil  
Sandhoefner, Lisa Koch, Ellen  
Grady

Disposition Date: 12/29/2010

Date Submitted: 12/22/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Master Policy 2010

Project Number: 7000GM-U-EZ 2010

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Filed in our  
domicile state of Nebraska on or about the  
same date.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Group Market Type: Employer, Association, Trust, Other

Explanation for Other Group Market Type:  
Union

Overall Rate Impact:

Filing Status Changed: 12/29/2010

State Status Changed: 12/29/2010

Deemer Date:

Created By: Mary Cleasby

Submitted By: Mary Cleasby

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

*SERFF Tracking Number:* MUTM-126940969 *State:* Arkansas  
*Filing Company:* United of Omaha Life Insurance Company *State Tracking Number:* 47577  
*Company Tracking Number:* LISA KOCH  
*TOI:* H21 Health - Other *Sub-TOI:* H21.000 Health - Other  
*Product Name:* Master Policy 2010 - 7000GM-U-EZ 2010  
*Project Name/Number:* Master Policy 2010/7000GM-U-EZ 2010

**Filing Description:**

RE: NAIC #: 261-69868 FEIN: 47-0322111  
United of Omaha Life Insurance Company  
7000GM-U-EZ 2010 Master Policy  
10634GA-EZ 0111 Application  
105GR-EZ 10 Premium Rider

On behalf of United of Omaha Life Insurance Company, I am submitting the above-captioned forms in final printed format for your review and approval. These forms contain no unusual or controversial items, according to normal company and industry standards. To the best of my knowledge, they comply with all your applicable statutes.

These forms are new and do not replace any forms previously filed.

Policy 7000GM-U-EZ 2010 is an incorporation master policy designed to accommodate all of our products, including Life, Accidental Death and Dismemberment, Short Term and Long Term Disability and Dental Benefits. The incorporation master policy contains the basic contractual information. We then incorporate the certificate booklets of specific products which results in the entire group insurance policy.

Application 10634GA-EZ 0111 is a group insurance application used by the Policyholder to request coverage.

Premium Rider 105GR-EZ 10 is being filed to reflect the combination of coverage and premium options selected by the Policyholder.

We request approval of these forms on a general-use basis. These forms reflect administrative changes to our group insurance forms. Therefore, there is no rate consideration or any change to our rate manual pages.

Your review and approval of this filing will be appreciated. Please feel free to contact me with any questions or concerns.

Sincerely,

Lisa Koch  
Product and Advertising Compliance Analyst  
Regulatory Affairs  
Phone: 402-351-6937  
Fax: 402-351-5298

SERFF Tracking Number: MUTM-126940969 State: Arkansas  
Filing Company: United of Omaha Life Insurance Company State Tracking Number: 47577  
Company Tracking Number: LISA KOCH  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: Master Policy 2010 - 7000GM-U-EZ 2010  
Project Name/Number: Master Policy 2010/7000GM-U-EZ 2010  
E-mail: Lisa.Koch@mutualofomaha.com

## Company and Contact

### Filing Contact Information

Lisa Koch, Product & Advertising Compliance lisa.koch@mutualofomaha.com  
Analyst  
Mutual of Omaha 402-351-8473 [Phone]  
Mutual of Omaha Plaza 402-351-5298 [FAX]  
Omaha, NE 68175

### Filing Company Information

United of Omaha Life Insurance Company CoCode: 69868 State of Domicile: Nebraska  
Mutual of Omaha Plaza Group Code: 261 Company Type: Life Insurance  
Omaha, NE 68175 Group Name: State ID Number:  
(402) 351-6420 ext. [Phone] FEIN Number: 47-0322111

## Filing Fees

Fee Required? Yes  
Fee Amount: \$150.00  
Retaliatory? No  
Fee Explanation:  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United of Omaha Life Insurance Company	\$150.00	12/22/2010	43171008

<i>SERFF Tracking Number:</i>	<i>MUTM-126940969</i>	<i>State:</i>	<i>Arkansas</i>
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<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
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<i>Project Name/Number:</i>	<i>Master Policy 2010/7000GM-U-EZ 2010</i>		

## Correspondence Summary

### Dispositions

<b>Status</b>	<b>Created By</b>	<b>Created On</b>	<b>Date Submitted</b>
Approved-Closed	Rosalind Minor	12/29/2010	12/29/2010

<i>SERFF Tracking Number:</i>	<i>MUTM-126940969</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Company Tracking Number:</i>	<i>LISA KOCH</i>		
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>Master Policy 2010 - 7000GM-U-EZ 2010</i>		
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## Disposition

Disposition Date: 12/29/2010

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

Comment:

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>MUTM-126940969</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>United of Omaha Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>47577</i>
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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Supporting Document</b>	PPACA Uniform Compliance Summary	Approved-Closed	Yes
<b>Supporting Document</b>	Memorandum of Variability	Approved-Closed	Yes
<b>Form</b>	Master Policy	Approved-Closed	Yes
<b>Form</b>	Application	Approved-Closed	Yes
<b>Form</b>	Premium Rider	Approved-Closed	Yes

SERFF Tracking Number: MUTM-126940969 State: Arkansas

Filing Company: United of Omaha Life Insurance Company State Tracking Number: 47577

Company Tracking Number: LISA KOCH

TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other

Product Name: Master Policy 2010 - 7000GM-U-EZ 2010

Project Name/Number: Master Policy 2010/7000GM-U-EZ 2010

## Form Schedule

### Lead Form Number: 7000GM-U-EZ 2010

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/29/2010	7000GM-U-EZ 2010	Policy/Cont Master Policy ract/Fratern al Certificate	Initial		0.000	7000GM-U-EZ 2010 Master Policy.pdf
Approved-Closed 12/29/2010	10634GA-EZ 0111	Application/ Application Enrollment Form	Initial		0.000	10634GA-EZ 0111 Master Application.pdf
Approved-Closed 12/29/2010	105GR-EZ 10	Policy/Cont Premium Rider ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		0.000	105GR-EZ 10 Premium Rider.pdf

# UNITED of OMAHA LIFE INSURANCE COMPANY

Mutual of Omaha Plaza, Omaha, NE 68175

a stock company

Home Office: Mutual of Omaha Plaza, Omaha, Nebraska 68175

This Policy is issued to [V] ("the "[Policyholder]").

This Policy is a legal contract between the Policyholder and Us. It is issued in consideration of payment of premiums and the Policyholder's application.

[This Policy will be interpreted under the Employee Retirement Income Security Act of 1974, as amended (ERISA). This Policy is issued in the State of [Name of State]. To the extent state law is not preempted by ERISA, and only to that extent, this Policy will also be interpreted under the law of the State of [Name of State], without giving effect to the principles of conflicts of law of that State or any other state. Any part of this Policy which is in conflict with the applicable laws of the State of [Name of State] is changed to conform to the minimum requirements of that State's laws.]

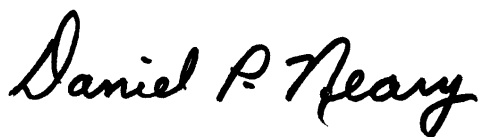
[This Policy is issued in and will be interpreted by the laws of the State of [Name of State], without giving effect to the principles of conflicts of law of that State or any other state. Any part of this Policy which is in conflict with the laws of the State of [Name of State] is changed to conform to the minimum requirements of that State's laws.]

This Policy is effective [V] at the [Policyholder]'s main office.

We agree to pay benefits subject to the terms, conditions, and limitations of this Policy.

The Certificate is made a part of this Policy.

**GROUP POLICY NO. [V]**



**Chairman of the Board and  
Chief Executive Officer**



**Corporate Secretary**



## **GENERAL PROVISIONS**

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Capitalized terms are defined in the Certificate or other documents made a part of this Policy.

### **PREMIUM CHANGES**

We reserve the right to change premium rates any time after:

- (a) the most recent premium rate guarantee date described in this Policy;
- (b) there is an increase or decrease of [V]% or more in the [Policyholder]'s [employee] population or the number of [employees] insured under this Policy;
- (c) Our liability or cost of administration is changed due to a change in federal, state, or local law;
- (d) this Policy's terms are changed; or
- (e) there is a change which materially affects the risk assumed for insurance provided by this Policy.

We must give the [Policyholder] at least [V] days advance written notice of any premium rate change.

### **PAYMENT OF PREMIUMS**

The premium for this Policy equals the sum of the individual premiums for each Insured Person. The first premium is due on the effective date of this Policy. Subsequent premiums are due on the [V] day of each subsequent month or other modal period agreed to in writing by an authorized representative in Our home office. Premium payments must be made to Our home office or to a location We designate, using a payment method We accept. We will consider premium to be paid on the date We receive it.

### **GRACE PERIOD**

This Policy has a [V] day grace period. This means that, except for the initial premium, if the premium is not paid on or before the date it is due, it may be paid in the [V] day period that follows. This Policy will stay in force during the grace period, unless the [Policyholder] gives Us written notice that this Policy will terminate during the grace period. If We receive such notice, We will terminate this Policy on the date requested.

### **TERMINATION**

Following at least [31] days advance written notice to the [Policyholder], We have the right to terminate this Policy:

- (a) if the number of [employees] insured is less than [V] or less than [V]% of those eligible for insurance;
- (b) any time after the most recent premium rate guarantee date described in this Policy; or
- (c) if the [Policyholder] does not perform any of its duties under this Policy.

The [Policyholder] has the right to terminate this Policy at any time. The [Policyholder] must give Us written notice of at least [31] days before the date this Policy is to terminate, unless the [Policyholder] gives Us written notice that this Policy will terminate during the grace period.

This Policy will automatically terminate at the end of the grace period if the [Policyholder] fails to pay its portion of the premium.

If this Policy terminates for any reason:

- (a) all unpaid premiums up to the date of termination are due, including premiums for the grace period or any part of the grace period; and
- (b) all unpaid premiums are due no later than the date of termination.

Termination of this Policy will not affect benefits otherwise payable for a claim incurred while this Policy is in force.

### **REINSTATEMENT AFTER TERMINATION**

If this Policy terminates for any reason, the [Policyholder] may request to reinstate it. We will reinstate only if:

- (a) an authorized representative in Our home office agrees in writing to reinstate this Policy;
- (b) the [Policyholder] agrees in writing to accept any written conditions of reinstatement that We impose;
- (c) all past due premiums are paid, including any premium for the time insurance was in effect during the grace period; and
- (d) the premium due from the date of reinstatement until the next premium due date is paid.

## **CERTIFICATES**

We will issue the [Policyholder] a Certificate for delivery to each Insured Person. The Certificate describes the benefits, terms, conditions, exclusions and limitations of the insurance provided under this Policy.

## **MISSTATEMENT OF AGE OR GENDER**

If an Insured Person's age or gender is misstated, We may adjust the premium or the benefits payable. An adjustment of the benefits payable will be based on what the premium would have purchased at the correct age or gender.

## **INCONTESTABILITY**

We will not contest this Policy after it has been in force two years, except for nonpayment of premium.

## **[POLICYHOLDER] RESPONSIBILITIES**

The [Policyholder] will notify[:

- a) both the Insured Person and Us when the Insured Person's insurance under this Policy ends if the Insured Person ceases to be eligible for insurance under this Policy;
- b) each Insured Person and Us when insurance under this Policy ends if this Policy is terminated and is not replaced by another policy or plan with no interruption in coverage[; and
- c) Us when the amount of insurance coverage for which an Insured Person is eligible changes].

Notice shall be provided within [15] days from the date insurance ends[ or the amount of insurance coverage changes for the Insured Person]. Notice to the Insured Person shall include information about any options available to continue or obtain insurance.

[If We do not receive notice under a) above within this [15] day time period, We may require the [Policyholder] to reimburse Us for the amount of any claims paid on behalf of any ineligible person [and/or any dependents of such person] during the time the person was ineligible. The [Policyholder] must reimburse Us for claims under this provision within [30] days after receipt of Our written request for payment.]

The [Policyholder] is responsible for keeping the following records:

- a) persons insured by classification and any persons eligible but not insured;
- b) the amount of money the [Policyholder] contributes toward premiums;
- c) beneficiary designation information, if applicable; and
- d) any other information which We may reasonably request.

The [Policyholder] will provide Us with copies of these records upon request. These records must be open to Us for inspection at any reasonable time.

The [Policyholder] will provide, as We require, any information on Our forms which is needed for insurance administration.

[The [Policyholder] is responsible for enrolling eligible persons for coverage under this Policy and performing other administrative duties agreed to by Us. The [Policyholder] will perform its responsibilities in accordance with the terms of this Policy and Our policies and procedures. The [Policyholder] may delegate some of its responsibilities to a third party. The [Policyholder] agrees to indemnify and hold Us harmless from and against any and all claims, actions, damages, liability and expenses, including, without limitation, reasonable attorneys' fees, arising from or related to the failure of the [Policyholder], or a third party to whom the [Policyholder] has delegated its responsibilities, to perform its responsibilities in accordance with the terms of this Policy or Our policies and procedures.]

## **ASSIGNMENT**

No assignment of this Policy is binding upon Us unless an officer in Our home office agrees to it in writing and not until it is recorded with Us at Our home office.

**UNITED OF OMAHA LIFE INSURANCE COMPANY**

[Mutual of Omaha Plaza  
Omaha, NE 68175]



**Mutual of Omaha**  
Home Office Use Only  
Policy Number(s): \_\_\_\_\_

**Group Insurance Application**

**Applicant** (Full Legal Name) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Requested Effective Date** \_\_\_\_\_

If this application is approved, insurance will become effective on the requested effective date, unless United of Omaha Life Insurance Company sends written notice of a different effective date.

<b>Coverage(s) being applied for</b>	<b>GROUP (Contributory / Non-Contributory)</b>	<b>[GROUP] VOLUNTARY (100% Employee Paid)</b>
<input type="checkbox"/> Life	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> AD&D	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Short Term Disability	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Long Term Disability	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dental	<input type="checkbox"/>	<input type="checkbox"/>

**ACKNOWLEDGMENT AND SIGNATURE**

All statements in this application and any claims experience data provided to United of Omaha Life Insurance Company are true and complete and will be relied upon by United of Omaha Life Insurance Company to determine whether to issue a policy. Such statements and claims experience data, along with the group insurance proposal from United of Omaha Life Insurance Company, are the basis for any policy issued by United of Omaha Life Insurance Company. Any incomplete, incorrect or misleading statements or data may void this application and any issued policy as of the effective date.

If an authorized representative at United of Omaha Life Insurance Company's Home Office does not approve this application, no insurance is in effect at any time and any advance payment received will be returned.

This application is submitted with an advance payment of \$ \_\_\_\_\_

**Signature of Applicant's Authorized Representative** \_\_\_\_\_

**Typed or Printed Name of Authorized Representative** \_\_\_\_\_

**Title** \_\_\_\_\_ **Date** \_\_\_\_\_

**Name of broker, agent and/or insurance agency** \_\_\_\_\_

**[Fraud Warning:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, may be guilty of a crime and may subject such person to criminal and civil penalties.]

**[[Arkansas][District of Columbia][Louisiana][New Mexico][West Virginia] Fraud Warning:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

**[California Fraud Warning:** For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.]

**[Colorado Fraud Warning:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties

may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.]

**[[Delaware][Florida][Oklahoma] Fraud Warning:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.]

**[[Maine][Tennessee][Virginia][Washington] Fraud Warning:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.]

**[[Maryland][Oregon][Rhode Island] Fraud Warning:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

**[New Jersey Fraud Warning:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

**[New York Fraud Warning:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.]

**[Ohio Fraud Warning:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.]

**PREMIUM RIDER**

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This rider is made a part of Group Policy [V].

This rider is effective [V].

**CLASSIFICATION(S)**

[V]

**[LIFE INSURANCE PREMIUMS**

[The [monthly] premium for each \$[V] of Life Insurance for each [Employee] is as follows:

[Tobacco]  
[Non Tobacco]

Age of [Employee][Spouse]	[Monthly] Premium
[Less than [V] .....	..\$[V]]
[V but less than [V] .....	..\$[V]]
[Age [V] and over.....	..\$[V]]]

[The [monthly] premium for each \$[V] of Life Insurance for each Dependent Spouse is as follows:]

[Tobacco]  
[Non Tobacco]

Age of [Employee][Spouse]	[Monthly] Premium
[Less than [V] .....	..\$[V]]
[[V but less than V] .....	..\$[V]]
[Age [V] and over.....	..\$[V]]]

[The [monthly] premium for [all Dependent children][each Dependent child] is \$[V] per [unit per][month][for each \$[V] of insurance].]

[[Employee][,][ and] [Dependent Spouse] [and] [all Dependent children]..... ..\$[V] per [unit per][month][for each \$[V] of insurance]]

[[Dependent Spouse] [and] [all Dependent children] .....\$[V] per [unit per][month] [for each \$[V] of insurance]]

[[All Dependent children][Per Dependent child].....\$[V] per [unit per][month] [for each \$[V] of insurance]]

[V]]

**[ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PREMIUMS**

[The [monthly] premium for Accidental Death and Dismemberment Insurance is:

[Tobacco]  
[Non Tobacco]

Age of [Employee][Spouse]	[Monthly] Premium
[Less than [V] .....	..\$[V]]
[[V] but less than [V] .....	..\$[V]]
[Age [V] and over.....	..\$[V]]]

[The [monthly] premium for each \$[V] of insurance for each Dependent Spouse is as follows:]

**[Tobacco]**  
**[Non Tobacco]**

<b>Age of [Employee][Spouse]</b>	<b>[Monthly] Premium</b>
[Less than [V] .....	.....\$[V]]
[V but less than [V] .....	.....\$[V]]
[Age [V] and over.....	.....\$[V]]]

[The [monthly] premium for [all Dependent children][each Dependent child] is \$[V] per [unit per][month][for each \$[V] of insurance].]

[[Employee][,][ and] [Dependent Spouse] [and] [all Dependent children].....\$[V] per [unit per][month] [for each \$[V] of insurance]]

[[Dependent Spouse] [and] [all Dependent children] .....\$[V] per [unit per][month] [for each \$[V] of insurance]]

[[All Dependent children][Per Dependent child].....\$[V] per [unit per][month] [for each \$[V] of insurance]]

[V]]

**[LONG-TERM DISABILITY INSURANCE PREMIUMS]**

[The premium is as follows:]

[The [monthly] premium for the Core Plan is:]

[\$[V] per \$[V] of [[Monthly] Covered Payroll] [Total [Weekly][Monthly] Benefits]]

[The [monthly] premium for the Buy-up Plan is:

\$[V] per \$[V] of [[Monthly] Covered Payroll] [Total [Weekly][Monthly] Benefits] (This premium is in addition to the [monthly] premium shown above for the Core Plan).]

<b>[Age of [Employee]</b>	<b>[per \$[V] of [[Monthly] Covered Payroll][Total [Weekly][Monthly] Benefits] [For each \$[V] of [[Monthly] Covered Payroll] [Total [Weekly][Monthly] Benefits]</b>
[Less than [V] .....	.....\$[V]]
[[V] but less than [V].....	.....\$[V]]
[Age [V] and over.....	.....\$[V]]]

[[[Monthly] Covered Payroll][Total [Weekly] [Benefits] is the [total] amount of Basic [Monthly][Weekly] [Earnings][benefits] for which all [Employees] are insured under the Policy.]

[[Employee].....\$[V] per \$[V]of [[monthly][weekly] benefits]][[Monthly] Covered Payroll]

[\$[V] per [Employee] per [month]]

[V]]

**[SHORT-TERM DISABILITY INSURANCE PREMIUMS]**

[The premium is as follows:]

[The [monthly] premium for the Core Plan is:]

[\$[V] per \$[V] of [[Monthly] Covered Payroll] [Total [Weekly][Monthly] Benefits]]

[The [monthly] premium for the Buy-up Plan is:

\$[V] per \$[V] of [[Monthly] Covered Payroll] [Total [Weekly][Monthly] Benefits] (This premium is in addition to the [monthly] premium shown above for the Core Plan).]

[Age of [Employee]	[For each \$[V] of [[Monthly] Covered Payroll] [Total [Weekly][Monthly] Benefits] [per \$V of [[Monthly] Covered Payroll] [Total [Weekly][Monthly] Benefits]
[Less than [V] .....	.....\$[V]]
[[V] but less than [V].....	.....\$[V]]
[Age [V] and over.....	.....\$[V]]]

[[[Monthly] Covered Payroll][Total [Weekly] Benefits] is the [total] amount of [monthly][weekly] [earnings][benefits] for which all [Employees] are insured under the Policy.]

[[Employee].....\$[V] per \$[V] of [weekly][monthly] benefits]  
 [V]]

**[DENTAL INSURANCE PREMIUMS**

The [monthly] premium is:

[[Employee] only.....	.....\$[V]]
[[Employee] and one Dependent.....	.....\$[V]]
[[Employee] and Family.....	.....\$[V]]
[[Employee] and Spouse.....	.....\$[V]]
[[Employee] and all Dependent children.....	.....\$[V]]

[V]]

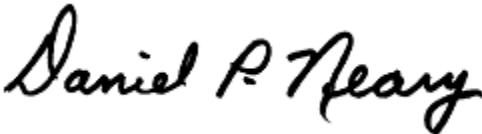
**[RATE GUARANTEE DATE**

[V] or any date thereafter agreed to in writing by Our authorized representative in Our home office.]

**[PREMIUM ALLOCATION**

The total amount of premium paid or remitted by the Policyholder for this Policy and any other group insurance policy the Policyholder has with Us or any of Our affiliates ("Other Policy") will be allocated to this Policy and each Other Policy on a pro-rata basis. This means that if the Policyholder does not pay or remit the full premium that is due for this Policy or any Other Policy by the due date, the full amount of premium for this Policy and each Other Policy will be past due, resulting in termination of this Policy and each Other Policy in accordance with the applicable grace period for this Policy and each Other Policy.]

UNITED OF OMAHA LIFE INSURANCE COMPANY



Chairman of the Board and Chief Executive Officer

SERFF Tracking Number:	MUTM-126940969	State:	Arkansas
Filing Company:	United of Omaha Life Insurance Company	State Tracking Number:	47577
Company Tracking Number:	LISA KOCH		
TOI:	H21 Health - Other	Sub-TOI:	H21.000 Health - Other
Product Name:	Master Policy 2010 - 7000GM-U-EZ 2010		
Project Name/Number:	Master Policy 2010/7000GM-U-EZ 2010		

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	12/29/2010
<b>Comments:</b>		
<b>Attachment:</b>		
AR Read Cert.pdf		

	Item Status:	Status Date:
<b>Bypassed - Item:</b> Application	Approved-Closed	12/29/2010
<b>Bypass Reason:</b> The application is being filed and is attached on the Form Schedule tab.		
<b>Comments:</b>		

	Item Status:	Status Date:
<b>Bypassed - Item:</b> Health - Actuarial Justification	Approved-Closed	12/29/2010
<b>Bypass Reason:</b> Not applicable to this filing.		
<b>Comments:</b>		

	Item Status:	Status Date:
<b>Bypassed - Item:</b> Outline of Coverage	Approved-Closed	12/29/2010
<b>Bypass Reason:</b> Not applicable to this filing.		
<b>Comments:</b>		

	Item Status:	Status Date:
<b>Bypassed - Item:</b> PPACA Uniform Compliance Summary	Approved-Closed	12/29/2010
<b>Bypass Reason:</b> Not applicable to this filing.		
<b>Comments:</b>		



<i>SERFF Tracking Number:</i>	<i>MUTM-126940969</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>United of Omaha Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>47577</i>
<i>Company Tracking Number:</i>	<i>LISA KOCH</i>		
<i>TOI:</i>	<i>H21 Health - Other</i>	<i>Sub-TOI:</i>	<i>H21.000 Health - Other</i>
<i>Product Name:</i>	<i>Master Policy 2010 - 7000GM-U-EZ 2010</i>		
<i>Project Name/Number:</i>	<i>Master Policy 2010/7000GM-U-EZ 2010</i>		

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	Memorandum of Variability	Approved-Closed	12/29/2010
<b>Comments:</b>			
<b>Attachment:</b>			
AR Read Cert.pdf			

**CERTIFICATION**

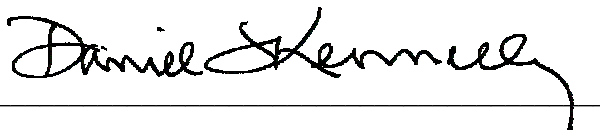
This is to certify that the attached form(s) has/have achieved the following Flesch Reading Ease Score(s) and complies/comply with the requirements of Ark. Stat. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<u>Form</u>	<u>Description</u>	<u>Score</u>
7000GM-U-EZ	Master Policy	55*
105GR-EZ-10	Premium Rider	53*
10634GA-EZ 0111	Master Application	50**

\*This score was achieved by removing language or terminology entitled to be excepted by your state's readability regulation.

\*\*When scored with the base policy.

Date: December 22, 2010



Daniel J. Kennelly  
Vice President & Chief Compliance Officer

**CERTIFICATION**

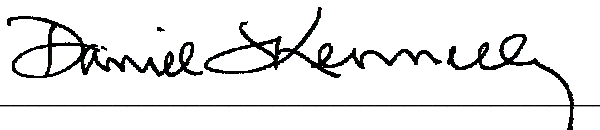
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Daniel J. Kennelly  
Vice President & Chief Compliance Officer